Governor's Council on Behavioral Health Care

Access To Services Subcommittee Report

December 2004

Executive Summary

In September and October of 2002 Rhode Island's Governor's Council on Behavioral Health identified consumer's difficulty accessing services as a topic worthy of further investigation by a subcommittee. This subcommittee limited its scope to identifying ways to overcome barriers that mentally ill, but not seriously mentally ill clients face accessing appropriate services. The subcommittee addressed the barriers they face when they first attempt to "get in the door" and the other set of barriers they face once they are "in the door." The subcommittee was also interested in determining how to keep the not seriously mentally ill from consuming large amounts of service dollars by accessing crisis services like hospital bed time, and keep them from ending up in the criminal justice system.

The subcommittee determined that problems with access to services start prior to admission and continue throughout clients interaction with the system if they get beyond the screening process. The reasons for these difficulties include:

- **Community mental health agency structures** such as different screening procedures for entry, waiting lists for services, and lack of adequate or highly trained staff.
- **Insurance and Medicaid coverage problems** such as limited capacity at existing providers, type of provider that can be reimbursed for mental health services is limited, and low Medicaid reimbursement rates.
- **Social or cultural issues** such as need for services not always recognized among elderly or primary care givers for the elderly, and lack of adequate culturally competent services.

The subcommittee also made the point that by investing in making services more accessible to those in need before they get into crisis situations can lead to significant savings in overall mental health, physical health, criminal justice expenditures and result in increased tax revenues. The subcommittee made the following recommendations:

- **Improve timeliness of services by implementing statewide adherence to a standard risk scale**
- **Implement additional hospital diversion services**
- **Implement a therapeutic model for mentally ill prisoners**
- **Increase support for prison diversion programs**
- **Increase services to people with co-occurring mental health and substance abuse disorders**
- **Locate more services strategically**
- **Focus attention on serving mentally ill elders**

A detailed explanation of these recommendations including action steps appear on pages 15 to 18. These recommendations are drawn from data and discussions in the body of this report.

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Introduction

In September and October of 2002 the members of the Governor's Council on Behavioral Health identified three behavioral health problems or issues that they would address. Three subcommittees were formed headed by a chair and vice-chair appointed by the Chair of the Governor's Council on Behavioral Health. Members of the larger council were asked to participate in at least one subcommittee. In addition to council members, most committees sought additional support from professionals in the community. The following report was prepared by the Access to Services Subcommittee. Barbara Inderlin, Director of Social Services, Saint Francis Chapel & City Ministry Center chaired this committee. Other contributors to this report include; Mitch Henderson, Wayne Cochran, Frank Spinelli, Tom Martin, Marie Strauss, Peter Mendoza, Joseph Le, Nancy Rosati, Corinna Roy, and Reed Cosper.

This subcommittee limited its scope to identifying ways to overcome barriers that mentally ill, but not seriously mentally ill clients face accessing appropriate services. The subcommittee addressed the barriers they face when they first attempt to "get in the door" and the other set of barriers they face once they are "in the door." The subcommittee was also interested in determining how to keep the not seriously mentally ill from consuming large amounts of service dollars by accessing crisis services like hospital bed time, and keep them from ending up in the criminal justice system.

Description of the Problem

Agency Structure

Problems with access to services start prior to admission. Each agency is set up to admit clients differently. Some agencies rely on an initial phone screening system that asks perspective clients for demographics, with a clinician re-contacting the client for a more thorough phone screening. Other agencies do a one stop shopping approach with an attempt to schedule appointments on the first contact through screenings gathered by non-degreed professionals or at a minimum a bachelor's level degreed professional. The other extreme, practiced by some agencies, is using a master's level clinician to do the phone screening and set up an appointment. Access to a system of care can also occur through emergency services in CMHCs when clients both access emergency services and get screened for entry into the system. Finally, national DOJ data says 6 of 10 inmates suffering from mental illness are not diagnosed. Access to services in prison requires proper screening at intake.

The goal for entry into the system is to develop easy access to all services so clients are not waiting for a call back from clinicians, or awaiting daily disposition meetings. Scheduling on the first contact has great merit, as clients who obtain appointments on the first call can be educated about the type of service/treatment they will have and be provided with the earliest appointment available. A consistent statewide philosophical approach to the problem of entry into the system would improve access to services. However, reorganizing to one consistent statewide system could cause staffing and financial hardships to provider agencies.

Another serious deterrent to accessing services is the time it takes to be assessed and the time between assessment and treatment. A large proportion of the capacity of the CMHCs is earmarked for the treatment of individuals with SPMI. Individuals with mental health needs who are not SPMI are often required to wait weeks or months for an initial screening appointment. Subsequent appointments can also be difficult to schedule due to limited capacity at the CMHC. Many individuals who would like assistance are discouraged by the long wait for services, and do not follow through.

It is critical for access agencies to abandon making people wait more than 30 days to be assessed. Usually waiting lists are not monitored closely and clients become discouraged to continue seeking treatment when placed on a waiting list. Another time span that needs to be reduced is the turnaround time between the initial request for service and the actual appointment. It will be shown later that funding an accessible system produces results. For example, employment and use of least intensive services appropriate for the client reduces the cost of a system that might otherwise deal only with clients in crisis who tend to use more expensive services and fail to receive the support they need to be productive members of society.

People with substance abuse problems who also have some mental health issues, but not severe enough problems to get services cannot get the mental health help that they need. There are few if any clinicians or psychiatrists available to diagnose their mental illness if they enter through the substance abuse door. Even if their needs are recognized there may not be services available to them.

Insurance and Medicaid

Medicaid provides a range of therapeutic and case management services to individuals with severe and persistent mental illness (SPMI). Medicaid beneficiaries who do not meet this classification but find themselves in need of mental health services often have difficulties accessing services. These access problems are of three types: (1) there is limited capacity at existing providers; and (2) the type of provider that can be reimbursed for mental health services is limited. There is a need for more state-funded general outpatient services for the uninsured and those on Medicaid. Finally, (3.) Medicaid reimbursement rates are so low that there is no incentive for providers to provide service.

Community Mental Health Centers (CMHCs) provide mental health services to Medicaid beneficiaries in Rhode Island. Some Medicaid beneficiaries who suffer from mental health problems may feel uncomfortable seeking services at an unfamiliar setting. These individuals (including the elderly and those with a primary physical disability) may be more comfortable seeking services at their usual service provider, such as their primary care physician. Medicaid limits the provider types and settings that can be reimbursed for mental health services for adults over age 21, making it difficult for providers such as primary care physicians to provide mental health services to their Medicaid patients. Medicaid benefits for the seriously mentally ill are different than for clients in the general outpatient (GOP) population. Because of the low rates and a limited benefit package, many mental health providers do not provide services to these clients.

Socio-Cultural issues

"Some of the barriers to receiving care and treatment of behavioral health issues for the elderly include lack of recognition by the elderly of the symptoms of the problems that include somatic complaints. If these complaints are reported to primary care physicians, they often go unrecognized as

treatable behavioral health disorders. Elders also resist acknowledging and seeking the care needed fearing a threat to their independence. Depression and anxiety often accompany acute as well as chronic illness and impede recovery or the potential for restoration of functioning. Adequate funding for behavioral health has lagged but even as parity becomes a reality, access to funding and adequate coverage for all elders is not currently available. An estimated 30% of the adult Medical Assistance population in Rhode Island who present with acute symptoms do not receive treatment. As their symptoms worsen, they are frequently seen in emergency rooms with a significant number requiring hospitalization for associated medical problems."[1]

In addition to overall capacity limitations, there is insufficient capacity to assist individuals whose primary language is not English. While there are some services available to seriously mentally ill clients who do not speak English, in the GOP population, services for non-English speakers and deaf individuals are inadequate to meet the need in the community. The State's mental health advocate has anecdotal evidence of many non-English speakers being incapable of even accessing service information on the telephone, let alone real services. Services for blind individuals and those with cognitive limitations are similarly limited. Although the Latino population in the state of Rhode Island has grown to be one of, if not, the largest minority population in the state, the associated services for this population have not kept up with the growth. There are presently only a handful of licensed or certified substance abuse counselors in the state of Rhode Island, and licensed mental health counselors who are bilingual/bicultural are even more rare then that. Presently the Latino populations are being treated at levels of care that may not be appropriate for their degree of trouble.

Characteristics of the Individuals and Families Affected by the Problem

In the United States population overall, approximately 22 percent of adults have experienced a mental disorder in the past year, while 10 percent have had a disability due to a diagnosable mental illness. Thirty-seven percent of females and 29 percent of males surveyed in Rhode Island indicated that they had at least one day of poor mental health in the past month.[2]

A 2001 survey of adults with physical disabilities and chronic health conditions in fee-for-service Medicaid found that 28.5 percent had both mental and physical health conditions. This rate was slightly higher for women than for men. Individuals reporting both mental and physical conditions had worse health status and were more likely to require immediate medical care. Over 14 percent of the respondents reported that their most serious health problem in the past year was a mental disorder, the second most commonly reported problem. Close to 37 percent of the respondents indicated a need for mental health counseling, but only 60 percent of those who needed the service were able to receive satisfactory assistance.[3]

[1] Behavioral Health Issues Among the Elderly in Rhode Island, Rhode Island Department of Elderly Affairs.
[2] NMIH "The Numbers Count" www.nimh.nih.gov/publicat/numbers.cfm. Based on 1998 data.
[3] Needs Assessment Survey of Rhode Island Working-Age-Adults with Physical Disabilities and Chronic Health Conditions on Fee-For-Service Medicaid, February, 2002.

The populations affected by access to care are obviously very broad. Clients range from the incarcerated client who has unsuccessfully attempted to access care, to an elderly individual referred by his or her PCP for counseling, but is unable to articulate his or her needs. People with co-occurring disorders and no insurance comprise the newest population identified with difficulty accessing services. These clients may not present with SPMI criteria initially, therefore they are referred to treatment for the "primary" problem and do not get treatment for their mental health issues. These untreated individuals often re-present in psychiatric, criminal or substance abuse systems. The recent rash of suicide attempts at ACI (4 attempts, 3 successful in April 03) vividly highlights the need for better screening and monitoring of those with mental illness in prison. This has become a public health issue.

Another group of clients who have difficulty accessing services are people who suffer from mental health and/or substance abuse concerns but do not qualify as state-supported Community Support Program (CSP) clients. If they were given access to psychiatric evaluations, and if warranted, given proper medication, they would be higher-functioning individual and quite possibly never become so impaired that they would end up in a psychiatric bed improperly. Some have estimated that 80-85 percent of our substance abuse clients suffer from some form of mental illness as well. The mental illness exacerbates the substance abuse use and vice versa. Most of the clients have PTSD, anxiety issues, depression, etc. They may, with proper medication and counseling or case management, be able to obtain employment, which would help offset housing and other costs, etc. With access to proper services these people could realize higher self-esteem, less incarceration, substance abuse and less anxiety and other symptoms of depression.

The Latino population in the state of Rhode Island is a young immigrant population mostly from Central and South America in a low socioeconomic level have problems with immigration and suffer from post traumatic stress disorder due to the revolutions and politics of people in the countries of origin. Most of them are un-insured and work at minimum paying jobs. The problems they bring to treatment are not only substance abuse related, but also mental health issues compiled with the fact that there are no services that can be provided for them in the native language. They tend to be far more damaged when they seek treatment; they also build in distrust for anything to do with government and anything to do with medical facilities that they are not familiar with and makes them a difficult population to engage.

It is estimated that one of every four elder Rhode Islanders will experience behavioral health issues that threaten or impair their ability to live independently. Depression and anxiety are the most prevalent behavioral health disorders that the elderly experience and they often co-occur with other behavioral health disorders such as substance abuse and gambling addictions. Suicide is the most dramatic outcome of depression, and suicide rates for persons 65 and older are higher than for any other group.[4]

[4] Hoyert DL, Kochanek KD, Murphy SL. Deaths: final data for 1997. National Vital Statistics Report, 47 (19). DHHS Publication No. 99-1120. Hyatsville, MD: National Center for Health Statistics, 1999.

The incidence of behavioral/mental health problems among the aging now under reported, is expected to increase dramatically with the aging of our population. "If you look at the current infrastructure for meeting the needs of people over 65, it is as if mental illness does not exist for this population."[5]

Poor access to services hits all kinds of people, particularly the unemployed, "working poor" or those with no insurance. Family stressors like divorce, children, dysfunctional family unit, unemployment, death or grief issues, domestic violence issues, anger management, and legal issues create barriers to accessing services. Other issues that work against people accessing services include substance abuse, lack of education, homelessness or housing issues, DCYF or criminal justice involvement, lack of access to FIP due to criminal justice, lack of primary medical care, poor self-esteem, non-CSP clients dually diagnosed typically suffering from PTSD, anxiety, depression, or other mental health disorders.

Mental health problems impact individuals' ability to find and maintain employment and can hurt these persons' financial stability, family ties and community relationships. Lack of employment often severs insurance coverage. In addition, mental health concerns can increase use of hospital and emergency room care, particularly when other treatment settings are unavailable.

Mental health is the leading cause of hospitalizations for adults in fee-for-service Medicaid in Rhode Island. It is the third leading cause of emergency room visits. In Rhode Island, adults with a mental health problem have longer average hospital stays and (of individuals who have at least one stay) are more likely to have multiple stays than are those without a primary diagnosis of "mental disorder."[6] Among individuals who visit the ER for care, those with a principal diagnosis of mental disorder are more likely to have multiple emergency room visits than are those who visit the ER for other reasons.

Where Services Should be Located

The location were people access mental health services should be expanded and available in a number of settings including substance abuse service providers. If this is not possible, they should be accessible through a realistic referral process from these service centers. The new GOP RFP addressed this issue. It is expected that the new service system will provide "enhanced" dual-diagnosis services – which include a defined referral process, although not necessarily "integrated" services – which is the more holistic approach, throughout the state.

DSA funded slots should not be restricted by location. The use of third party payers and the federal government should be maximized to help pay for services. The savings of treating people and returning them to working taxpayers will make this cost effective.

Financial Resources Needed to Support Services

[5] Jeste Dilip et al, "Consensus Statement on the Upcoming Crisis in Geriatric Mental Health: Research Agenda for the Next Two Decades," Arch Gen Psychiatry. Volume 56, September 1999.

[6] "Mental disorder" is a diagnosis attached to the hospital claim paid by Medicaid.

Answering this question requires several weeks of professional state people to cost out. First, a detailed model of services is needed (an expansion of above). Then staffing requirements need to be estimated followed by costing. Next, benefits need to be figured and a cost benefit analysis completed. The full-time presence of 2-3 people, perhaps including a consultant, is recommended.

Consequences of Not Providing the Needed Services

The State and society incur many different costs when a person has an extended mental illness, even if not "serious" according to the State rules for access to public mental health treatment. As a well-documented example, it was estimated that 2000 costs for depression alone in the U. S. were about $83.1 billion dollars, $51.5 billion in the workplace. This translates to about $308 million (total) and $191 million (workplace) respectively for Rhode Island. Depression in the United States also results in over 200 million days lost from work each year. Unquestionably, the State and families incur major costs when people have a "non-serious" mental illness as depression often is.

Figure 1 summarizes all mental health and substance abuse costs to society in the United States and, by extrapolation, Rhode Island. Rhode Island costs were extrapolated by using the RI to US population ratio. According to the US census bureau in 2002 the U.S. population was 288,369,000, and the R.I. population was 1,069,725. Rhode Island's population represents approximately 3.7 percent of the U.S. population; therefore, the assumption was made that the costs to Rhode Island would be approximately 3.7 percent of the costs of the nation.

Figure 1 presents an example of how one might look at the costs of both providing services—the "direct" cost, and the cost of not ensuring that those with mental illness (not the seriously mentally ill) are treated and productive—the "indirect" costs (lost productivity, SSDI payments, SSI payments), and other costs like premature death and incarceration. In addition, this Figure shows the costs associated with substance abuse for the nation, and, by extrapolation, the costs of substance abuse in Rhode Island.

This "big picture" summary shows that behavioral health costs and their indirect costs are staggering. Does this mean State government need be burdened with many of these costs for years and years to come? We believe not.

A major reason for these high costs is under-funding of prevention and treatment. For example, in the State of Washington, where there is excellent documentation, government spending on substance abuse in 1996 was $248 for every resident only about $10 of this amount went to prevention and treatment. Yet, as a result,

- There were 2,824 deaths in 1996 caused by or related to alcohol or drug abuse (70,000 years of potential lives lost). The two leading causes of these deaths were alcohol, 2,318; and substance abuse, 506[7].

- Of 217 arrests for homicide, 65 were alcohol-related and 22 drug-related.

- There were 16,000 drug or alcohol related hospital discharges.

[7] The substance abuse deaths broke down into 353 car accidents, 291 alcohol cirrhosis deaths and 223 suicides.

Rhode Island's numbers are obviously much smaller but the burden per resident is similar. To illustrate this, in the figures that follow, we roughly estimate the costs Rhode Island State government now incurs when people who are mentally ill and/or substance abusers lose their job and remain out of the work force because they are under or uninsured, and untreated. This 18-64 year adult group is largely responsible for hidden State costs since children and the elderly are well insured due to Right Care and Medicare. In essence, the 18-64 year old age group is the last group to be fully served. As we will see, the State is losing millions of dollars in revenue and unnecessary spending by not fully serving a target subgroup of this population.

FIGURE 1 SUMMARY ESTIMATE OF MENTAL HEALTH AND SUBSTANCE ABUSE COSTS TO SOCIETY IN 2002

	U.S. Costs ($ Billions)	Rhode Island Costs [A] ($Millions)
Mental Health [B]		
Direct	69	256
Indirect	79	293
Lost Productivity	63	234
SSDI Payments	11	41
SSI Payments	11	41
Premature Death	12	45
Incarceration	6	22
Total annual MH costs	**166**	**616**
Substance Abuse[c]		
Illicit Drugs	145	536
Smoking	138	511
Alcohol	166	614
Total annual SA costs	**532**	**197**
Total (2002 estimate) [D]	**698**	**259**
Per Resident Cost	$2,420	$2,420

[A] Rhode Island costs were extrapolated by using the RI to US population ratio. Values used were US: 288,369,000; RI: 1,069,725: source: US Census estimate for July 1, 2002.

[B] Sources were Mental Health: A Report of the Surgeon General, Chapter 6; Healthy People 2010-Conference Edition, Chapter 18 Mental Health and Mental Disorders, 1996; and NAMI Omnibus Mental Recovery Act brochure which expanded the mental health productivity information 1990.

C Issue Brief: Substance Abuse, Facing the Costs, Center on the Aging Society, Georgetown University (1995)

[D] As noted previously in the table, cost data was estimated in the 1990s. To update this data, we assumed 3% annual growth in these figures. This is believed to be a very conservative estimate because health care costs rose at well over 5% per year during this time frame.

Figure 2 is a detailed list of estimated existing costs and potential net savings for various cost areas. The left side of the figure presents per client costs, the number of assumed clients is listed in the middle. The three columns on the right show the annualized State cost in 2002, the cost of new initiatives, and their resulting savings. The 2002 costs include hospitalizations. The savings are a

straight-line reduction of the total cost of mental health services minus the projected cost of new services. It should be noted that some of the cases in the more accessible system would still require hospitalizations and ER utilization. Regardless, some of these savings could be realized the same year that new initiative expenditures are incurred although an analysis of this exact effect has not been made. Basically, the question is how quickly can a person be treated and obtain a job. This is a big "If." We need to realize that to create a completely accessible system, a very large infusion of dollars will be required, although the long-term savings will be great.

Figure 2 shows that, presently, the State incurs lost tax revenues because this population is not working. It (or the public) also incurs costs for emergency room visits, hospitalizations and the like. But with new initiatives like treatment, job placement and the like, about 60+% would shift to the job side of the equation, many within a year. As an example, diverting a person from serving time in ACI ($57,900 cost with recidivism) to public housing/treatment/job placement ($41,000 average, successes and failures) saves about $18,000 per year.

FIGURE 2: ROUGH ESTIMATE OF SAVINGS TO STATE GOVERNMENT

State Government Cost item	Cost Per Client		Number of persons directly affected N=12,802	Annual State Cost in $ Million		
	Cost of existing system	Cost of accessible system		Cost of existing system	Cost of accessible system	Savings
Lost Tax Revenues						
Individual	$1,130	$407	12,769	$14.0	$5.0	$9.0
Sales (general)	$704	$253	12,769	$8.7	$3.1	$5.6
Suicide	$37,200	$1,800	33	$1.2	$0.1	$1.2
Mental health/Medical	$3,370	$1,800	9,561	$32.2	$17.2	$15.0
Prison Costs	$61,200	52,200	3208	$196.5	$167.3	$29.2
Estimate of other costs	$489	$153	12,802	$6.3	$2.0	$4.3
Total Costs	$20,223	$15,209	12,802	$258.9	$194.7	
Total Savings			**12,802**			**$64.2**

Note: The costs associated with HIV and HVC have not been included, see Appendix A-2 for this information

With this as background, assumptions supporting Figure 2 fiscal estimates follow. The data regarding lost tax revenue was developed using the following assumptions. Based on FY2002 $808.8 million total income tax received divided by 542,410 tax returns ($1,491). Data from RI Tax Administration and State Budget. This is the average for the State and includes many high income/high tax individuals. If household incomes above $100,000 are eliminated, US Census Bureau household income decreases from $37,787 to $28,664 or 24%. As a first estimate, we assume income tax for households less than $100,000 reduces 24% so applicable tax loss is $1130.

Based on US Dept. of Labor and Bureau of Labor Statistics Unemployment Insurance data, the average re-employment rate after 1 year is 64%. A Health Care for Communities study in 1998 indicated that 73.4% of adults 18-64 with "other" mental health disorders were employed; the percent was 82.8% for those with substance abuse disorders. We assume that, with proper treatment and help obtaining a job, 64% of our population obtain work within 12 months. Consequently, 36% of Income tax and sales tax will still be lost after treatment.

Based on FY 2002 general sales tax of $745.7 million divided by census of 1,058,920 (decreased by 24% as above). Tax data from RI Tax Administration; population from Census Bureau. The same arguments as for State Income Tax apply.

Data in Figure 2 regarding suicide was calculated in the following way: 81 deaths per year occurred on the average in RI between 1989 and 1998 per US Center for Disease Control and Prevention. More than 90% of suicides are mental health related according to NIMH The Numbers Count; this equates to 73 of 81 people in RI. We assume that 40 of these are SMI related and 33 are non-SMI. (The possible range of values is 0 to73; our assumption is near the middle for this population.) Based on Greenberg reference #1 1990 findings escalated to 2002. These are societal costs based on the human capital approach that implies the productive value of an individual is cumulative lifetime earnings expressed in current dollars. To arrive at the State loss of revenue, we multiple the present value of the lost income stream ($581,300) by the tax revenue to income ratio (($1130+$704)/$28,664 derived above) to arrive at $37,200. This neglects the substantial impact on the rest of society i.e., $581,300-$37,200 equals $544,100 much of which would have gone to the family

The mental health/medical data is based on the assumption that there are approximately 1215 individuals requiring the State to pay for one hospitalization (7.3 days @ $1075/day) and three ER visits at $300 each. The remaining less serious cases have $300 worth of emergency room visits only (no hospitalization). This results in an average $3,370 per client. Treatment plan costs are assumed to be 20 CMHC visits at $75 each plus 20% for vocational assistance for a total of $1800. The savings result from a reduction in hospitalizations and emergency room visits.[8]

The savings under the prison category are derived from looking at the average ACI annual cost/inmate, which is $36,547. This data comes from the RI Dept. of Corrections Costs per Offender-FY 2002 Expended. Included here are the costs of housing 13,893 people awaiting trial; they spend an average 20.2 days in prison at an approximate cost $93.68 per day or $11.6 million in total. An additional $10.3 million (not included in the $36,547 calculation) is spent on community-based offenders (probation and parole, home confinement and women's transitional housing.).

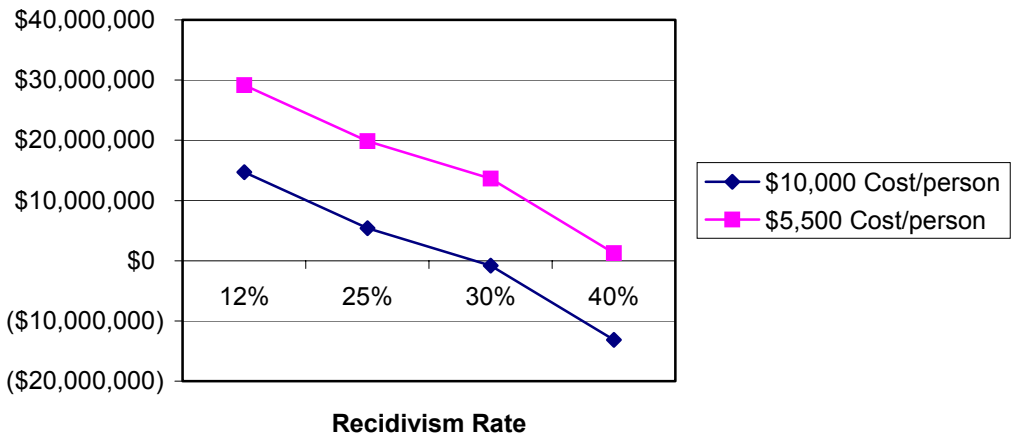
Prison savings is primarily a function of diversion and transition costs and achieved recidivism rates following these services. In figure 2, these costs were assumed to be $5,500 each and resulting recidivism was assumed to be 12% vice the present 50%. These may be optimistic assumptions.

Figure 3 plots prison savings as a function of recidivism rates and diversion/transition costs (we assume the cost of these services could range between $5,500 to $10,000). A wide range of savings are possible depending upon the effectiveness of the prevention services (and the resulting recidivism rate). Other jurisdictions appear to have strong reductions in costs as measured by jail days, number of arrests, hospital days and number of hospitalizations but the data is limited[9]. A more accurate estimate requires a pilot study and/or more data from other jurisdictions. Still, from these few samples, substantial savings appear possible and the likelihood of negative savings appears small.

[8] Data from Departments of Human Services and Mental Health, Retardation and Hospitals, F. Spinelli (DHS) and J.Murray (MHRH), Sept. 2003.

[9] For example, in Cook County, Chicago, in a medium sized sample (n=30), jail days reduced 82%, arrests reduced 52%, and hospital days went down 86% for jail savings of $5,255/person and hospital savings of $30,500 per person.

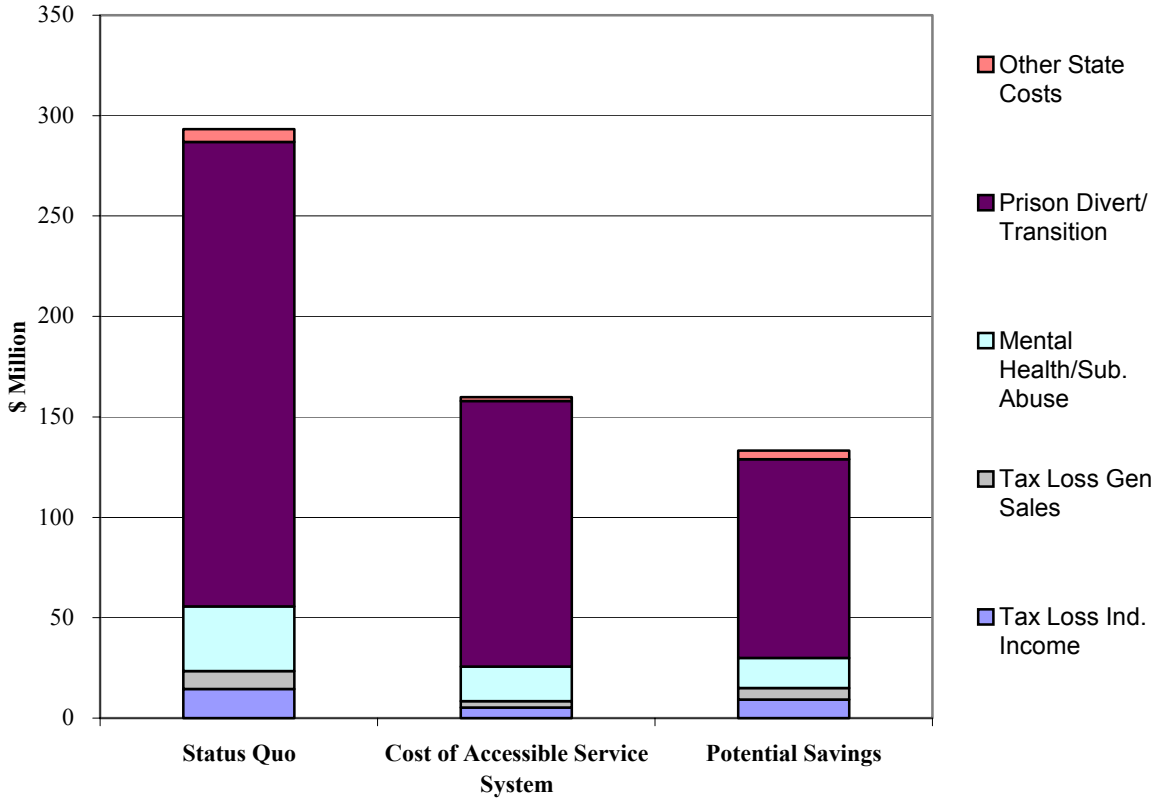
Figure 3 Diversion and Transition Savings



Finally, "other" costs excludes items like Social Security, Medicare, General Public Assistance, Family independence, free DOT, and vocational rehab services, which can total to more than the costs above. For this analysis, we conservatively assumed a figure of 2% of the items above for "other State costs".

Figure 4 presents a proposed alternative to continued waste. The first bar shows the cost of the current system, the middle bar in the graph shows the cost of prevention strategies totaling $ 195 million, and the third column shows the estimated savings of about $64 million annually. There are several reasons why the first bar is so high; behavioral health costs are high due to expensive emergency room visits/hospital care provided to uninsured/unemployed people during a behavioral crisis is also costly. The main reasons for large prison costs are: the increasingly large number of people entering the court system, high inmate costs/year plus high recidivism due to numerous causes such as lack of housing and good jobs. Planned treatment on an on-going basis could greatly lessen these excursions into high cost/day situations. Various mental health, substance abuse, concurrent HIV/Hepatitis C prevention programs, and robust job renewal services, including items like temporary housing, rehabilitation and job placement are proposed as the alternate. Specific, alternative funding amounts are listed in the references along with the analyses used to develop them.

FIGURE 4: POTENTIAL SAVINGS FROM PROVIDING TREATMENT



It is noted that an additional $195 million is not required to implement these strategies - $195 million is the result. For example, diverting more than half awaiting admission drives down prison costs – they would have spent less than 6 months in prison but would have returned, sometimes again and again. We shown that a large number diverted or transitioned from prison will have costs of around $6000-$10,000 per year vice $62,000 spread over several years now. Even so, over 1000 inmates serving longer than average sentences will continue to cost us $119 million of the $167 million shown.

It may seem counter-intuitive that additional money on treatment and prevention will save the state so much. The major reasons are weak prevention programs, weak programs for released inmates, and the lack of employment going hand-in-hand with treatment. The lack of these services causes serious problems. For example, regarding the lack of prevention funding, people who may have avoided crisis situations go into crises that result in expensive emergency room and hospital visits that the state pays for since the people are uninsured and unemployed. The alternative, of course, is diagnosis and treatment programs for the mentally ill and substance abusers while they are insured, or, at least prior to hospitalization.

Inmates leaving prison, and offenders who should not enter prison are a special case, but an expensive one. These people in our population need treatment too and especially when not in prison where they are not now served. For example, it does no good to treat inmates in prison and not continue treatment when they leave. Right now, most leaving prison would experience gaps in coverage because of poor access to services (e.g., due to high backlogs at community mental health centers or ineligibility). It seems obvious that those involved in the criminal justice system at any stage should be on the highest priority lists for treatment, prevention, and job help because the state (and society) will pay dearly if client stays in the criminal system. Thus, an inmate leaving prison may need transitional services like temporary housing, a temporary job, job training and the like if he or she is to obtain a sustainable job and break this cycle.

Treatment and prevention programs need an end goal of sustainable jobs for all clients. This priority cannot be understated. A meaningful job, with benefits, can mean:

- The client becomes an income producer rather than burden to society.
- Many clients will pick up health insurance with their job leading to no need for continued state behavioral health support.
- Partial or incomplete services that don't result in a job for the majority of this population are probably wasted…they continue the cycle rather than breaking it.

There are literally dozens of assumptions based on national and local data used to create this economic result. Here is a partial list of some reasons our estimated savings may be low or high:

Some reasons savings estimate may be low	**Some reasons savings estimate may be high**
• Savings due to more, high-payoff HIV-Hepatitis prevention measures aren't included • Savings due to diversion of people before they get to the court system aren't included • 5% of total costs is used to estimate items not included in the analysis. This number is likely quite low. • On the average, it may take less than one year from initiation of treatment for the client to obtain a job • Secondary effects like impacts on families were not considered • The total impact on society was not considered	• Assumed number of clients don't obtain sustaining jobs • Assumed Diversion and transition costs in court system are too low. Housing costs and job training costs are examples • Reduced Recidivism rates may not be attainable in this State as they have been elsewhere • The number with mental health or substance abuse issues who can be logically diverted from prison may be lower.

Despite these uncertainties, it is clear that high-payoff actions should be quickly initiated to lower costs to the State (and society). Many good models and best practices are available to help implement these concepts.

Appendix A-3 is a Fact Sheet that highlights specific inroads made in lowering costs through sound prevention and treatment. Concrete examples of some program results in other states and nationally show that, if anything, our preceding estimates may be very conservative.

Conservatively, expanding behavioral health and other services to cover the unemployed, under or uninsured, and untreated populations can save over $130 million per year. Achieving these cost reductions requires investment but with extraordinary returns. Access to services: behavioral health services, health screening, housing, and job training and placement are all important if the goal of return to society is to be achieved. We believe the strategy outlined in this paper will ultimately produce more jobs, improve health, and lessen homelessness and crime; we recommend its components be vigorously pursued. The court and prison systems should be a high priority since many in this population reside there. Close co-operation between State Departments and Agencies for an integrated strategy is recommended.[10]

Recommendations

- **Improve timeliness of services by implementing statewide adherence to a standard risk scale**

One way to manage the timeliness in which clients are seen is to define clients' need for treatment on a scale of severity, for example, a person with an "emergency" disposition would need to be seen in 1 hour, a person with a "potential risk" disposition would need to be seen in 24 hours, a "hospital discharge" would need to be seen within 48 hours, and persons considered "routine" would need to be seen in 7-10 days. While several state-funded facilities use some version of this, it may not be widely used. This scale will need to be clearly defined.

A definition accepted statewide based on discussions with stakeholders should be developed that delineates who should be treated and into what service area they belong (i.e. CSP, outpatient, Substance Abuse, etc.) may be needed as well as a discussion regarding who agencies are mandated to treat. A revised definition of seriously and persistently mentally ill was developed and test piloted at two Community Mental Health Centers. This definition emphasized functionality of individuals and allowed new diagnoses to be included. Those impacted by this new definition could include individuals with co-occurring disorders, clients with Alzheimer's, CIS/children referrals/aging out DCYF referrals and individuals who have been in prison. The pilot indicated that a small number of individuals who would not originally have been included as CSP clients would now be allowed services. While this number was small, due to proposed cuts in 2004 and the potential for future funding issues, MHRH was not able to implement this new definition. MHRH will continue to

[10] (The team approach between DOH and MHRH on HIV/Hepatitis is a good model here. An extensive point paper on the co-operative process used can be obtained from Mr. Paul Lomberti, Dept. of Health).

monitor the impact this definition would have upon the system and hopes to implement these changes in the future.

- **Implement additional hospital diversion services**

Hospital Diversion services could range from each CMHC having crisis beds, to an intensive outpatient/crisis program, with access to a psychiatrist within 48 hours. A case manager would also be needed for coordination of care. This service or treatment should be available to clients 48-72 hours after hospitalization (if that has occurred), and available to clients within 72 hours after a request for services. (It could have an impact on hospital diversion for the uninsured if services are available---especially available psychiatrist time).

- **Implement a therapeutic model for mentally ill prisoners**

While this report does not focus primarily on the seriously and persistently mentally ill (SPMI), it should be noted that services to the SPMI population in prison are not as accessible as they are in the community. The SPMI in prison would benefit most from a therapeutic model. The prison population that is not SPMI, referred to in this report as the GOP population would benefit from an integrated approach to care in which both substance abuse and mental health needs are treated. In addition, clients with Mental Health/Substance Abuse/Criminal issues would best be served by good transitional planning prior to discharge. After discharge a care team should include a Probation worker and a psychologist for testing information and treatment planning for cognitive/behavioral treatment. A restriction would have to be applied whereby these clients would go back into prison (similar to a criminal court order) if treatment were not followed. Linkage with the court system and probation officer would be important.

- **Increase support for prison diversion programs**

This recommendation has been formulated in recognition of the fact that substantial resources are being wasted every day solutions are not put in place. SPEED IS CRITICAL. Services needed to be provided to people before they enter prison and while they are in prison such as robust screening and diagnosis, then treatment like any other person in society. Caseworkers and social workers should be available to provide services before booking through the entire criminal justice process including prison and after discharge. Prison personnel need anti-stigma training such as that offered by On Our Own of Maryland. Transition services near discharge such as temporary housing and jobs, continuance of medical treatment, and social networking opportunities. Most important is initiation of treatment at a community mental health center for all inmates diagnosed as mentally ill, regardless of the severity of their illness. Reason: Huge cost of re-entry into prison or hospital due to lack of treatment.

A project crisis team with dedicated membership from all departments should be formed to implement proven concepts with high benefit to cost ratios. This might include, Jail/court diversion, robust jail transition services, expanded CMCH staffs to keep wait times for all clients below 30 days for initial screening and follow-up and full medical screening of inmates.

For each concept, an in-house State team should be assigned to develop a detailed model of services needed in this area. Next, benefits need to be figured and a cost benefit analysis completed. Then staffing requirements need to be estimated followed by costing. Finally, an implementation plan is needed for each concept. Concepts should be ranked based on several criteria including payoff, population size, etc. The full-time presence of 4-6 people for each concept, including consultants as necessary, is recommended. Full support of departments at the highest levels will be required to speed development and implementation. Project budgetary and administrative support is mandatory.

Implementation teams need to be formed in tandem with above. They should be educated on the concept and provided full research material. Inter-departmental co-operation should be fostered.

For each concept, measures of performance at the system and organizational level should be developed to aid in later management initiatives. Data collection plans should follow this development. Example graphs and tables of data presentations should be previewed to top management across department lines.

The Governor's office should be manned and prepared to fight legislative and administrative battles needed to help implement the concepts expeditiously.

Status Quo	Added Prevention Strategies
• Prevalence HIV : About 3000 • Prevalence AIDS: About 1,021 • Prevalence HCV: About 18,000 • Combined Prevalence of HIV/AIDS/HCV = Approx. 20,500 • Prison inmate population accounted for 22 % of new HIV cases (90 of 418) from 2000 to 2002 (testing is done only upon intake, infection in the prison isn't known)	**Recommended program changes** • **Primary prevention** (to prevent the onset of a disease) • Although there is a state law mandating the offering of HIV testing in mental health and substance abuse facilities, dedicate state resources to screen all entering these programs for HIV/HCV. • Create mechanisms to continue and improve co-ordination between state agencies and community based organizations Dedicate funding for more comprehensive approach to prevention focusing on mental health, substance abuse, communicable disease prevention

Economic Ramifications	Recommended Secondary and Tertiary prevention
• Early detection of each of these diseases is critical in light of the advanced medical interventions. Secondary prevention is important too. Estimates relating to lifetime HIV costs ranges from $150,000 to $500,000. • For HCV, an estimated 70% of all liver transplants are a result of this devastating illness. With costs exceeding $250,000 per transplant, medical intervention to minimize risk and damage to the liver is essential. Prevention is a key public health policy. • Strategy resulting in improvements is in place with Federal and State funding. More needs to be done to lower number of new cases and large expenditures per case.	• Supplement federal HIV/AIDS dollars with a comprehensive medical treatment plan that assists in minimized advanced disease and premature death. • Create more HIV and HCV positive prevention programs so as to minimize transference of infections

- **Increase services to people with co-occurring mental health and substance abuse disorders**

There are some services available now to people with co-occurring disorders through six partnership grants, and via providers who provide both services. However, the six partnerships have been able to use the funding they received to provide some typically unfounded services like psychiatric assessments and medication management to substance abuse clients. These interventions have been very effective in serving the clients with co-occurring disorders, but as soon as they leave the program they loose funding for/access to meds, and psychiatric services.

- **Locate more services strategically**

On the one hand, reducing duplication of services might make the system less fragmented. On the other hand, by locating services in underserved areas some geographical barriers to treatment could be removed. For example, placing additional treatment facilities along bus lines and in underserved areas (Central Falls, Pawtucket, and Woonsocket and South Providence). The State has recently redesigned the substance abuse outpatient system, which will hopefully alleviate some of the problems in that part of the behavioral health system.

- **Focus attention on serving mentally ill elders**

The following initiatives, in order of priority, are recommended to address behavioral health issues among the elderly:

1. *Increase access to behavioral health treatment for the elderly:* expand the mental health provider network to include licensed and credentialed psychologists, clinical social workers and psychiatric clinical nurses in community agencies and private practice. This would include outreach to isolated elders in their homes through home and community care services. Currently, in Rhode Island, Community Mental Health Centers provide comprehensive services to the severely and persistently mentally ill, but lack the capacity to respond to the behavioral health problems described above.

2. *Behavioral health outreach to the elderly:* implement continuous behavioral health awareness programs in sites where the elderly live and centers where they congregate that include recognition of behavioral health issues and information on resources for care.

3. *Suicide prevention:* replicate and implement a model suicide prevention program for the elderly throughout Rhode Island.

4. *Primary care physician training:* Implement professional educational/training for primary care physicians to recognize behavioral health symptoms and provide or refer for effective treatment.

5. *Aging network staff training:* develop and deliver on-going training on behavioral health issues to the aging network staff including but not limited to social workers, residential service coordinators (housing) and all program staff (including meal site managers). Training and education will increase awareness of signs/symptoms of mental illness, thus increasing referrals to appropriate resources to provide care and treatment services.

Appendix A-1: Financial Justifications

A recidivism rate of 50% (50% within 3 years and 34% within 1 year), an average 1.5 prison visits over 3 years, and an average time served of 1.32 years results in total average cost per inmate of about $72,300 over 3 years (and $64,600 over 2 years). Sources: RIDOC sentenced releases 2003, and DOC handout with 1995 recidivism data.

The 50+% recidivism rate means 50% of released inmates return to prison, and 50% of these return again, and so on. Summing this mathematical series results in a number slightly larger than the 1.5 visits assumed above, but these incremental extra visits take place 6 years or more away.

The average stay in RI ACI is calculated as follows:

Average Admissions Sentences 2002-2003 (in months) are shown in the table below:

FY	Overall	< 6 month sentence	> 6 month sentence
2002	12.62	3.13	29.14
2003	12.86	2.97	35.13
Combined	12.74	3.0453	31.93

These values are based on RIDOC 2002 and 2003 data files with the average sentences recomputed for accuracy.

FY 2003 Sentenced release information shows 91% of sentences were served. Thus, the values in the table above must be multiplied by 0.91 to arrive at average sentences served for each category.

To estimate the potential prison population with mental health or substance abuse problems that diversion and/or transitional services could help, we need to know the number of first offenders, misdemeanors, the young, and small crime offenders who might be eligible for diversion programs.

We assume that all offenders with sentences less than 6 months fall into this category, and that all offenders with sentences greater than 6 months would be incarcerated then provided transitional services while and after leaving prison.

Based on these criteria and 2002/2003 admission data, 66.4% of ACI admissions could be diverted.

The estimate of the number with mental health or substance abuse issues in the ACI population is based on a recently published Human Rights Watch report (Ill-Equipped: US Prisons and Offenders with Mental illness, 2003. Their reference is a 2002 National Commission on Correctional Health report). They state that 17.5-26.8% in State prisons have serious mental illness and 36.6-55.2% have lesser (type 2) mental health difficulties. This totals to 54.1-82.0% of the prison population having a diagnosable mental health condition. Similarly, the number of substance abusers in prison is estimated as 70-90% (source: lecture by Dr. Fenton, University of Maryland at Second Annual MHRH/DOC Conference on Prisons September 2003). Finally, SAMHSA estimated 72% of those with mental illness in prison have co-occurring substance abuse issues. **Given this data, it can be shown that nearly all in prisoners suffer from one or both of these two problems. Subtracting a nominal 20% as seriously mentally ill (which agrees well with several studies), we assume 80% of those entering prison are either non-seriously mentally ill or substance abusers or both.** In summary, an average 3208 admissions (2002-2003) x 66.4% x 80% equals 1704 inmates who are in our population and can be diverted. (For this study, we assume the 20% with serious mental illness remain in prison. (This is a conservative assumption since at many of those SMI individuals with short sentences could be treated in less expensive environments too. Finally, those 34% of the total inmates with sentences greater than 6 months would enter prison and receive transition services.

Mental health and substance abuse treatment costs for clients who are diverted before entering prison are assumed to be 20 visits @ $75 ($1500). people diverted before prison or those leaving prison need additional help: continuation in outpatient service, and prevention costs like vocational training, temporary housing and a temporary job until the client has a stable job. These services are known as jail diversion/transition services; they are an investment to help break the cycle of return to prison. Assume a mix of 50% of clients to have costs as follows: training $2000, temporary housing $2000, temporary living expenses and food $2000 less public service $1000; net cost $5000. The other 50% are assumed live with family/friends so their net cost is $3000. This results in an average diversion cost of $4000; this plus the $1500 treatment costs results in $5500 total treatment/prevention costs. (Sources: F. Spinelli (DHS) and Murray (MHRH)). Additionally, through mental health and HIV/Hepatitis screening of all awaiting trial is assumed to be $250 per person.

Diversion and transition expenses needed to produce very low recidivism rates have varied in the limited data available. We assume that $5500 is a lower bound and $10,000 an upper bound on expenses.

Several diversion programs (see appendix A-4 for examples) have been shown to decrease recidivism rates by 76%. We use a value of 50% x .24 or 12%. We also see what savings exist at 24%, 30% and 40% recidivism rates. (It is noted that Vermont's substantial diversion program reduced recidivism from 10% to 6.7% in 2002.)

The ACI Offenders with sentences greater than 6 months average.31.9 months sentence of which 91% is served (27.5 months). We include costs of time served in the second and third year, and recidivism

costs, in our analysis and thereby show the total cost of an inmate in one year. Thus, we start with 3208 and track their total costs.

In summary, in this population, we assume that 1704 potential inmates could be diverted and 1504 in prison could receive transitional services when leaving.

One could also argue that additional "diversion" dollars should be spent before booking and within the court system to supply all courts with clinicians trained in mental health and substance abuse. Police officers could also be trained to properly handle this population as has been done in Memphis, TN, Annapolis, MD and Berkeley, CA. (Often, booking can be prevented). Together, these are known as diversion services. They are intended is to keep out of prison those who can more appropriately (and cheaply) be treated outside of prison. The court diversion costs have not been included here but are believed to be a manageable number: in RI, we need say 5 more court clinicians (say $400,000/yr to cover additional courts) and police/court personnel training (say $300,000). We note that, for this investment, the payback in savings is in hundreds of a percent. For example, the one-clinician team in the Providence RI court claimed to have diverted over 1100 potential inmates last year. (personal conversation with James Forker, MSCP, QMMP, Clinical Supervisor at the Office of the Public Defender, Oct 2003.) This important diversion technique is not included in this study effort due to uncertainties in service costs.

We note that these preliminary estimates could have wide variances: an inmate might need 10 months of housing instead of 3; his or her treatment costs could be several times higher, job training cost exceed our first estimates. We suggest more research in this area (as well as the prison parameters mentioned before) to refine the estimates and decrease cost uncertainties. (see outcome measures in Appendix A-4 for example). Nevertheless, because status quo prison costs are so high relative to these prevention/job training costs (say $37,000 versus $5500), even if our $5500 estimate is 200-300% low, we see substantial savings are still possible (see figure 3).

Finally, we address hospital costs for the court/prison population. We conservatively assume the same average hospital/ER costs of $3370 for the general population. This results in a hospital/ER cost of $3370 per person for those not diverted or transitioned. Actual costs of hospitals and Ers should be much higher but are undocumented in RI. Costs for those diverted or transitioned are assumed to be 86% less based on several results from other jurisdictions (see footnote 9 for example).

[1] This line item excludes items like Social Security, Medicare, General Public Assistance, Family independence, free DOT, and vocational rehab services, which can total to more than the costs above. For this analysis, we conservatively assumed a figure of 5% of the items above for "other State costs".

Appendix A-2: Fact Sheet on Mental Illness and Substance Abuse

Mental Illness in the Criminal Justice System

*Approximately 5 percent of the US population have a serious mental illness. The US Department of Justice reported in 1999, however, that about 16 percent of the population in prison or jail reported that they had a mental illness. A 2002 report to Congress by the National Commission on Correctional Health Care states that between 17.5 and 26.8% in prison have serious mental illness and an additional 36.6-55.2% have other mental disorders.

A study conducted in New York State found that men involved in the public mental health system over a five-year period were four times as likely to be incarcerated as men in the general population; for women the ratio was six to one.

Characteristics of People with Mental Illness who are Incarcerated

* Nearly three-quarters of inmates with mental illness have a co-occurring substance abuse problem.

* Inmates with mental illness in state prison were 2.5 times as likely to have been homeless in the year preceding their arrest than inmates without a mental illness

Nearly half the inmates in prison with a mental illness were incarcerated for committing a nonviolent crime.

Costs Incurred by Taxpayers when a Person with Mental Illness is Arrested, Incarcerated, and/or Hospitalized

* Officials in King County, Washington, identified 20 people who had been repeatedly hospitalized, jailed or admitted to detoxification centers; in the course of one year, providing these emergency services to these 20 individuals cost the county at least $1.1 million. (This is $55,000 per person)

Innovative Programs' Impact on Costs and Public Safety

Staff from the Thresholds Jail Program, which provides case management for people with mental illness released from jail in Cook County Illinois, calculated the number of days that 30 people who had been through the program were incarcerated and/or hospitalized in the year after their participation in the program. In total, the 30 individuals spent approximately 2,200 days less in jail (at $70/day) than they had during the year preceding their participation in Thresholds. These same 30 people also spent about 2,100 fewer days (at $500/day) in hospitals.

Using Law Enforcement Resources More Efficiently

* In Memphis, Tennessee, before the implementation of their Crisis Intervention Team (CIT) model, officers spent 4-6 hours at the medical center for mental health admissions, which now average about 15 minutes. Shortly after the Memphis CIT was implemented, injuries suffered by individuals with mental illnesses caused by police decreased by nearly 40 percent.

In 1999, the Albuquerque Police Department, which also employs a CIT model, reported that officers arrested, transported to jail, or otherwise took into protective custody fewer than 10 percent of those people with mental illnesses they contacted. Injuries were also reduced to just more than 1 percent of calls after their CIT model was implemented. The decrease in use of SWAT was reported at 58 percent.

(The above examples were taken from the Criminal Justice/Mental health Consensus Project Fact Sheet available at http://consensusproject.org/topics/factsheet. There are full references at this site.)

Substance Abuse Facts

"Medicaid spends 1 or every 5 dollars on hospital care for untreated alcohol and drug abuse problems." The Cost of Substance Abuse to America's Health Care System, Columbia University, 1993

"Substance abuse treatment cuts drug use in half, reduces criminal activity up to 80%, and reduces arrests up to 64%**". The National Treatment Improvement Evaluation Study (NTIES). Office of Evaluation, Scientific Analysis and Synthesis, SAMHSA, 1997**

"…addicted patients have compliance rates comparable to patients receiving treatment for diabetes, asthma and hypertension". O'Brien, Charles, MD et al, Physician Leadership on National Drug Policy, 1998

"According to several conservative estimates, every 1$ invested in addiction treatment programs yields a return between $4 and $7 in reduced drug-related crime, criminal justice costs, and theft alone. when savings related to health care are included, the savings can exceed costs by a ratio of 12 to 1**". Principles of Drug Addiction Treatment: A Research-Based Guide, NIDA, 1999**

Appendix A-3: A Primer on Prison Diversion

(extracted from United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, The TAPA Center for Jail Diversion Web site) and from consensusproject.org Web site

Because prison diversion can save so much money for the State and society, and because it is so efficient at improving access of mental health and substance abuse clients, a description of this concept and some results around the country are included in this appendix.

Background

The GAINS Center estimates approximately 800,000 persons with serious mental illness are admitted annually to U.S. jails. Moreover, among these admissions, the preponderance (72 percent) also meet criteria for co-occurring substance use disorders. As community-based mental health services have dwindled, law enforcement departments and jails have become de facto providers to persons with co-occurring disorders.

Over the past two decades, jail diversion programs have been offered as a viable and humane solution to the criminalization and inappropriate criminal detention of individuals with mental disorders. Diverting certain individuals from jail to community-based mental health treatment has been heralded for its potential benefits to the criminal justice system, the community and the diverted individual.

Definition

The term "jail diversion" refers to programs that divert individuals with serious mental illness (and often co-occurring substance use disorders) in contact with the justice system from jail and provide linkages to community-based treatment and support services. The individual thus avoids or spends a significantly reduced time period in jail and/or lockups on the current charge.

Types of Jail Diversion Programs

Depending on the point of contact with the justice system at which diversion occurs, the program may be either a pre-booking or post-booking diversion program.

Pre-booking diversion occurs at the point of contact with law enforcement officers before formal charges are brought and relies heavily on effective interactions between police and community mental health and substance abuse services. Most pre-booking programs are characterized by specialized training for police officers and a 24-hour crisis drop-off center with a no-refusal policy that is available to receive persons brought in by the police. The most recognized program is the Crisis Intervention Team (CIT) as developed by Memphis, TN. This model has been replicated in over 20 communities and the program received over 150 requests for technical assistance in one year.

Post-booking diversion is the most prevalent type of diversion program in the United States. These programs identify and divert offenders with mental illness after they have been booked and are either in jail or in arraignment court. Diversion program staff work with prosecutors, public defenders, attorneys, community-based mental health and substance abuse providers and the courts to develop and implement a plan that will produce a disposition outside the jail. The individual is then linked to an appropriate array of community-based services.

Specialty courts, such as mental health courts, are an increasingly visible form of post-booking diversion programs. Though no one definition exists (Steadman et al, 2002), according to Goldkamp, JD and Irons-Guynn C. (2000) and Griffin et al (2002), mental health courts have at least 3 elements in common:

(1) A mental health court is typically a specialty court docket or docket handling only cases of defendants with mental illness;

(2) Mental health courts restrict their dockets to non-violent misdemeanants who are diagnosed with mental illness; and

(3) A central purpose is to divert defendants from incarceration to community treatment and supports as quickly as possible. It should be noted, however, that some argue that mental health courts achieve diversion from incarceration only to the extent that court monitoring does not last longer than the individual would have otherwise spent in jail (see www.urbanjustice.org).

It is important to distinguish jail diversion from discharge or transition planning. Discharge planning activities should be part of usual criminal justice processing and occur only when the detainee would ordinarily leaving the jail as his/her case is being handled by the court. By contrast, jail diversion is a special, targeted program to short circuit usual criminal court processing to the benefit of the detainee, the correctional staff and the community.

To properly understand the policy debates around diversion, it is important to recognize that criminal justice and mental health professionals often use the term "diversion" differently. Diversion has a more restricted meaning in criminal justice than in mental health and that often gets in the way of collaboration.

For many criminal justice professionals diversion usually means either not filing or dropping charges in exchange for voluntary agreement to participate in some type of community-based programs. Under this arrangement, there is no continuing criminal justice supervision while the person completes the program as the prosecutor and the criminal court rescind any control over the case. A notable exception is specialty courts (e.g. drug courts and mental health courts where continuous judicial supervision is a key program element).

For mental health professionals, diversion is used to include any alternative to incarceration that involves community-based treatment. The alternatives may be voluntary or involuntary, that is, they may involve continuing criminal justice supervision while criminal charges or sentence are continued or held in abeyance for a specified period during which the client must meet the terms and conditions of treatment. Accordingly, options for diversion would include: (1) treatment as a condition of bail; (2) deferred prosecution; (3) deferred sentencing; and (4) pleading guilty with treatment as a condition of probation. With the broader concept of diversion, there is often much more willingness by prosecutors

and the courts because they retain jurisdiction and help insure that the treatment expected is actually received.

Key Features of Jail Diversion Programs

There are six key features that have emerged as essential for creating a successful jail diversion program. These elements are crucial in linking the criminal justice and community treatment systems.

1. Coordinating services at the community level with a high level of cooperation between all parties. In order to effectively divert detainees with mental illnesses from jail to appropriate mental health treatment, it is crucial that the agencies within a jurisdiction learn to work together even when their goals and expectations may appear to conflict. An adequate response cannot be expected if the mental health service needs of the inmate are defined simply as the jail's problem.

2. Regular meetings of all the key players. The right people need to be around the table early and often to get the program started. Key agency participants are the sheriff's department, the county mental health department, the county board of supervisors, the district attorney's office, the public defender's office, judges, the probation department, substance abuse treatment providers, housing providers (both public and private), and the county jail. Representatives from each of these key agencies should be involved from the beginning so that all parties are working toward the same goal. Once the program is off the ground, the key players should continue to meet regularly to coordinate services and share information about problems, resources, and other issues that may come up.

3. Liaisons, or boundary spanners, who are responsible for linking the judicial, correctional, and mental health pieces of a program. Boundary spanners represent a key element for effective communication between agencies. This is a term from the organizational literature that has special relevance to diversion programs. A boundary spanner is a core position responsible for directly managing the interactions between the correctional, mental health, and judicial staff. This position can help to overcome obstacles that arise due to the differing views and issues and policies inherent in coordinating the resources of three systems toward a singular goal.

4. A strong leader with the ability to foster excellent working relationships among the key players. This leader must have good communication skills and an understanding of the systems involved and the informal networks needed to put the necessary pieces into place.

5. Aggressive, early identification in the first 24 to 48 hours of detention. This is done through the initial screening and evaluation that takes place in the arraignment court or at the jail in the case of post-booking programs.

6. Case managers who are somewhat nontraditional with cultural diversity and prior experience in both criminal justice and mental health. It is important that there is cultural diversity within the case management team that resembles the diverse jail population. Case managers must have experience and a level of understanding of the people and their values and attitudes towards treatment.

Examples

Call the TAPA Center today (866) 518-TAPA (8272) to find out more about jail diversion programs around the country. The TAPA Center has a comprehensive database of programs and access to thousands of articles on topics related to mental illness, criminal justice and homelessness.

Also visit the Program Examples Database (http://consensusproject.org/programs/) on the Criminal Justice/Mental Health Consensus Project web site. The Program Examples Database identifies and describes programs, policies, and other initiatives designed to improve the response to people with mental illness who come into contact with the criminal justice system.

Outcomes Studies on Jail Diversion

For nearly 30 years, jail diversion programs have had wide support as a way to prevent people with mental illnesses and substance use disorders from unnecessarily entering the criminal justice system by providing more appropriate community-based treatment. Although these programs have had wide support, very few systematic outcome studies have examined their effectiveness. There have been few published outcome studies for jail diversion programs. These include two police-based, two court-based and two jail-based programs (see Steadman, Morris and Dennis, 1995 for taxonomy of programs). All six were short-term follow-ups of small groups. Nonetheless, all six were consistent in their findings of success based on each program's goals.

Lamb and colleagues (1995) sought to determine whether emergency outreach teams composed of police officers and mental health professionals could assess and make appropriate disposition decisions for psychiatric crisis cases in the community. They followed 151 people encountered by the Los Angeles SMART emergency outreach teams and studied how many of these contacts resulted in jail. Of the 151 contacts, 80 were transported to a hospital setting, 69 were held on a 72-hour mental health hold in an inpatient setting and only 2 were jailed. The researchers concluded that the teams benefited from shared access to mental health and criminal justice records in making disposition decisions. The teams increased the percentage of mentally ill persons who had access to the mental health system.

Similar findings came from the study comparing the Memphis Crisis Intervention Team (CIT) with the Birmingham Community Service Officers (CSO) and a traditional mobile mental health crisis team in Knoxville (Steadman et al., 2000). The two police-based programs resulted in substantially fewer subjects being arrested than the comparable figure found in Chicago for routine police contacts of 16 percent (Sheridan and Teplin, 1981). In Memphis 2 percent of the CIT contacts were arrested and 13 percent of the CSO cases in Birmingham. In more than half of the encounters examined in all three programs, mentally ill subjects were either transported or referred to treatment; in a third of the encounters, program staff used specialized response procedures to provide crisis intervention or resolve the incident on the scene.

In two court-based studies outcomes were also better for diverted detainees than regularly processed persons with mental illness. Lamb and colleagues examined outcomes from a post-booking diversion program in Los Angeles County in 1995. The program provided mental health consultation to a municipal court. Follow-up information was collected one year after the arrest of a sample of individuals who were referred for diversion. Although 54 percent of the sample had what qualifies as

a poor outcome, a significantly larger proportion of subjects who were diverted to receive judicially monitored treatment had a good outcome compared with subjects who were not mandated to receive monitored treatment. In Hamilton County, Ohio, a study was also conducted to test the effectiveness of a court-based diversion program. Information on participants was gathered through detainee interviews, staff interviews, and record abstracts. The study found that diverted subjects had substantially less jail time during a two month follow-up with re-arrest and re-hospitalization also lower (Steadman et al., 1999).

A study of jail-based diversion in New Haven, Connecticut with a one-year follow-up also produced positive results. A group of 314 seriously mentally ill detainees were diverted out of jail and into mental health treatment. They were compared with a sample of 124 people who would have been eligible for diversion but were not diverted. For each group the authors compared the total days incarcerated in the year after index arrest. Analyses indicated that jail diversion significantly reduced incarceration time during the next year. The one-year follow-up showed that diverted subjects spent an average of 41 days in jail compared to 173 days for non-diverted subjects. The biggest reduction was in class D felons (Hoff et al., 1999). A second institution-based study was Project Link in Rochester, NY. All clients have passed through the Monroe County Jail, but the point of contact may be the jail, prison, or even state mental health hospitals. Its research on 46 clients admitted between October 1, 1997 and December 1, 1998 showed the mean number of jail days in the follow-up year as compared to the prior year dropped from 9.1 per month to 2.1 per month and the mean number of hospital days dropped from 8.3 to .3 per month. In addition, the monthly jail costs dropped from $672 per consumer to $157 and hospital and outpatient costs went from an average of $4,302 per consumer to $918.

In September 1997, the Substance Abuse and Mental Health Services Administration (SAMHSA) funded a three-year Knowledge Development and Application (KDA) on jail diversion. The goal of the KDA program was to develop new knowledge about ways to improve the prevention and treatment of substance abuse and mental illness. The KDA represented an advance over the other outcome studies in that it included several sites with diverse study subjects, collected extensive background information on diverted and comparison subjects, and gathered cost data from some of the sites (Steadman, et al., 1999).

SAMHSA selected nine sites with established diversion programs to assess the effectiveness of the pre-booking and post-booking jail diversion programs. These included three pre-booking programs (Memphis, Tennessee; Multnomah County, Oregon; Montgomery County, Pennsylvania) and six post-booking programs (Maricopa and Pima Counties, Arizona; Connecticut (6 cities); Lane County, Oregon; Hawaii; New York City; Wicomico County, Maryland). These programs are described in Steadman et al., 1999. The Research Triangle Institute was chosen to coordinate the initiative and the National GAINS Center of Policy Research Associates was chosen to provide technical assistance to the sites and assist in reporting the research findings.

From September 1998 to May 2000, sites identified diverted subjects meeting study intake eligibility criteria of a serious mental illness co-occurring with a substance use disorder. Comparison (non-diverted) subjects for each site meeting eligibility requirements were selected from populations with potentially similar subjects. Research staff interviewed subjects at baseline, three months and 12 months using an interview protocol developed by a national steering committee. Results from this study are forthcoming.

Programs that provide intensive community-based services to individuals with mental illness who have been involved with the criminal justice system have proven extremely cost-effective.

In Cook County, Il and Monroe County, NY, annual savings were 4$18,873 and $39,518 respectively as shown in consensusreport.org site.

Author's Note: CT has had a formal diversion prototype in place since 1997. Preliminary results are now available. The CT legislature, upon being briefed, mandated the diversion program be expanded statewide. Contact is Ellen Weber, Project Director, Jail Diversion Program, Department of Mental Health and Addiction Services, 410 Capitol Ave, Hartford, CT 06134, ELLEN.WEBER@PO.STATE.CT.US

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